

CHAPTER 3 SECTION 2

HOSPITAL AND OTHER INSTITUTIONAL REIMBURSEMENT

ISSUE DATE:

AUTHORITY:

I. INTRODUCTION

TRICARE reimbursement of a non-network institutional health care provider shall be determined under the TRICARE DRG-based payment system as outlined in [Chapter 6](#) or other TRICARE-approved method. Other methodologies must be proposed in writing and approved by the Contracting Officer. The procedures below are not required for reimbursement of the network providers of care. The contractor and network providers are free to negotiate any mutually agreeable reimbursement mechanism which complies with state and federal laws. Any agreement, however, in which the methodology deviates from the accepted contract proposal methodology and which is detrimental to the TRICARE beneficiary or to the government may be rejected by the Contracting Officer, and any agreement which calls for reimbursement at higher rates than those approved for standard TRICARE must be approved by the Contracting Officer.

II. PAYMENT OF CAPITAL AND DIRECT MEDICAL EDUCATION COST

A. General

The contractor will make an annual payment to each hospital subject to the TRICARE/CHAMPUS DRG-Based Payment System (except children's hospitals) which requests reimbursement for capital and direct medical education costs, CAP/DME. The payment will be computed based on [Chapter 6, Section 8](#). These procedures will apply to all types of CAP/DME payments (including active duty). All CAP/DME payments will be not-at-risk and will be made from the not-at-risk, letter of credit bank account (see OPM, [Chapter 3, Section 2](#)).

B. Payment Procedures

The contractor shall use the following procedures in making CAP/DME payments to hospitals:

- a. Receive claim or request for payment from the hospital.
- b. Compute the amount due for each hospital submitting claims during a month, stopping processing prior to check write.

c. On the first work day of the following month submit a voucher (see [paragraph II.E.](#) below) by express mail to TMA, CRM. (A fax copy is not necessary.)

d. After receiving clearance from TMA, CRM, continue processing through check write and mail out checks within two calendar days.

C. Adjustments For Underpayments

The contractor shall determine the amount of the underpayment and pay any additional payment to the hospital with the next group of checks being cut and report as a payment as described in [paragraph II.B.](#) above.

D. Recoupment Of Erroneous CAP/DME Payments

If the contractor overpays a provider for CAP/DME claims, the contractor shall follow recoupment procedures as specified in OPM, [Chapter 11, Section 4](#) to include offsetting overpayments against future payments.

1. Offset funds shall be included as credits on the monthly CAP/DME voucher for the month the credits were processed.

2. Collections shall be included as separate lines indicating the month the collection was deposited (normally the prior month).

3. Debts established under this paragraph and related transactions shall be reported on the monthly Accounts Receivable Report (see OPM, [Chapter 3, Section 9, paragraph 3.0.](#)).

E. Vouchers

1. Format

Hospital Name
Hospital Address
Hospital Provider Number
Period Covered
Amount Paid/Collected for Capital
Amount Paid/Collected for Direct Medical
Total Paid

2. Sort

By Type (e.g., standard or active duty)
By Fiscal Year of Bank Account
By Contract
By State
By Hospital

3. Attachments

Attached to the voucher are to be each hospital's request for payment and the

contractor's worksheet showing the payment computation or basis for adjusting a previous payment.

III. TRICARE INPATIENT MENTAL HEALTH PER DIEM PAYMENT SYSTEM

See [Chapter 7, Section 1](#), for additional instructions. See [paragraph II.](#), for voucher preparation instructions. Effective for all admissions occurring on or after January 1, 1989, non-network inpatient mental health care shall be paid based on a per diem rate determined by TMA and provided to the contractor. Network inpatient mental health care may be paid at a rate negotiated by the contractor which is different from the inpatient mental health per diem; however, a higher rate must be approved by the Contracting Officer and the beneficiary's cost-share must be computed to be the lesser of the amount which would apply under the per diem rate or the contractor-negotiated rate. The TRICARE-determined rate shall apply to any out-of-region beneficiaries who are admitted to the facility.

IV. INPATIENT MENTAL HEALTH HOSPITAL, PARTIAL HOSPITALIZATION AND RESIDENTIAL TREATMENT CENTER (RTC) FACILITY RATES

Effective with Fiscal Year 1998, contractors shall submit three iterations of inpatient mental health, partial hospitalization (Half Day three to five hours and Full Day six or more hours) and RTC rates by facility to the TMA, Office of **Medical Benefits and Reimbursement Systems-Aurora (MB&RS)**. This data shall be reported in ASCII Format on a 3.5 floppy disc. The information shall include the Name of the Facility, Provider Number and the Location of the Facility. For inpatient mental health facilities indicate whether the facility is high volume or low volume and if high volume, the date when the facility became high volume. In addition, if a high volume inpatient mental health facility or RTC has been limited to a cap amount, so indicate. (See [32 CFR 199.14](#) and [Chapter 7, Section 1 and 4.](#)) For those psychiatric hospitals affected by the deflator computation, the contractor shall submit the high volume rate no later than 30 days from the date the deflator factor is received. The data shall be submitted using the following format:

NOTE: After year 2000 change number of iterations to submit only current year.

A	B	C
1	Field Name	Picture Comments
2	Provider/Facility Number	X(9) Employer Identification Number
3	Fiscal Year	9(2) Current Fiscal Year plus the two previous Fiscal Year/Iterations
4	Facility Type	9(1) 1=Inpatient 2=Half Day Partial 3=Full Day Partial 4=RTC
5	Facility Name	X(40) Name of the Facility Providing the Treatment
6	Facility Street Address	X(30) Street Address of the Facility
7	Facility City	X(18) City Where the Facility is Located

A	B	C
8	Facility State or Country Code	X(2) State or Country Where Facility is Located (Alpha Code)
9	Facility Zip Code	X(9) Zip Code Where Facility is Located
10	Per Diem Rate (Separate Record for each Per Diem Rate)	9(7)v99 1=Inpatient High Volume Per Diem Rate 2=Inpatient Low Volume Per Diem Rate - Adjusted by Wage Index and IDME Factors 3=Half Day Partial Hospitalization Per Diem Rate 4=Full Day Partial Hospitalization Per Diem Rate 5=RTC Per Diem Rate
11	High Volume Indicator	X(1) Indicates if Facility is High Volume (1=True, 0=False)
12	High Volume Date	9(8) If High Volume Indicator is True - Date Facility Became High Volume YYYYMMDD
13	High Volume Per Diem or RTC at Cap Amount	9(7)v99 If Per Diem has been Limited by Cap Amount, Provide Capped Amount

V. BILLED CHARGES/SET RATES

When a beneficiary is not enrolled in TRICARE Prime, the contractor shall reimburse for institutional care received from non-network providers on the basis of billed charges, if reasonable for the area and type of institution, or on the basis of rates set by statute or some other arrangement. The basic guidance shall be that the beneficiary's share shall not be increased above that which would have been required by payment of a reasonable billed charge.

A. Verification Of Billed Services

Reimbursement of billed charges should be subjected to tests of reasonableness performed by the contractor. These tests should be used to protect against both inadvertent and intentional practices of overbilling and/or supplying of excessive services. The contractor should verify that no mathematical errors have been made in the bill.

B. Use Of Local Or State Regulatory Authority Allowed Charges

There are instances in which a local or state regulatory authority, in an attempt to control costs, has established allowable charges for the citizens of a community or state. If such allowable charges have been extended to TRICARE beneficiaries by consent, agreement, or law, and if they are generally (not on a case by case basis) less than TRICARE would otherwise reimburse, the contractor should use such rates in determining TRICARE reimbursement. However, if a state creates a reimbursement system which would result in payments greater than the hospital's normal billed charges, the contractor should not use the state-determined amounts.

C. Discounts Or Reductions

Contractors should attempt to take advantage of all available discounts or rate reductions when they do not conflict with other requirements of the Program. When such a discount or charge reduction is available but the contractor is uncertain whether it would conform to its TRICARE contract, TMA should be contacted for direction.

D. All-Inclusive Rate Providers

All-inclusive rates may be reimbursed if the contractor verifies that the provider cannot adequately itemize its bills to provide the normally required Health Care Service Record data. Further, the contractor must ensure that appropriate revenue codes are included on the claim (as well as all other required UB-92 information), even though itemized charges are not required to be associated with the revenue codes. When a contractor reimburses a provider based on an all-inclusive rate, the contractor shall maintain documentation of its actions in approving the all-inclusive rate. The documentation must be available to TMA upon request. (Also, see [Chapter 1, Section 22.](#))

VI. SPECIAL REIMBURSEMENT PROCEDURES FOR CERTAIN RESIDENTIAL TREATMENT CENTERS (RTCs)

The contractor shall pay the network RTCs based on agreements as negotiated by the contractor. Non-network RTCs (see OPM [Chapter 4, Section 4](#)) shall be reimbursed based on the rate established by TMA, using the methodology specified in [Chapter 7, Section 4](#).

VII. REIMBURSEMENT OF AMBULATORY SURGICAL CENTERS

A. General

1. Payment for facility charges for ambulatory surgical services will be made using prospectively determined rates. The rates will be divided into 11 payment groups representing ranges of costs and will apply to all ambulatory surgical procedures identified by TMA regardless of whether they are provided in a freestanding ambulatory surgical center (ASC), in a hospital outpatient clinic, or in a hospital emergency room.

2. TMA will provide the facility payment rates to the contractors on magnetic media and will provide updates each year. The magnetic media will include the locality-adjusted payment rate for each payment group for each Metropolitan Statistical Area (MSA) and will identify, by procedure code, the procedures in each group and the effective date for each procedure. In addition, the contractors will be provided a zip code to MSA crosswalk.

3. Contractors are required to maintain only two sets of rates on their on-line systems at any time.

4. Professional services related to ambulatory surgical procedures will be reimbursed under the instructions for individual health care professionals and other non-institutional health care providers in [Chapter 3, Section 1](#).

5. See [Chapter 9, Section 1](#) for additional instructions.

B. Payment Procedures

All rate calculations will be performed by TMA (or its data contractor) and will be provided to each contractor. In pricing a claim, the contractor will be required to identify the zip code of the facility which provided the services (for the actual location, not the billing address, etc.) and the procedure(s) performed. The contractor shall use the zip code to MSA crosswalk to identify the rates applicable to that facility and then will select the rate applicable to the procedure(s) performed. Multiple procedures are to be reimbursed in accordance with the instructions in the Policy Manual.

C. Claims

Claims for the facility charges and/or professional charges for ambulatory surgery services may be submitted on either a UB-92 or a HCFA 1500 claim form. When professional services are billed on a UB-92, the information on the UB-92 should indicate that these services are professional in nature and be identified by the appropriate CPT-4 code and pricing information.

VIII. REIMBURSEMENT OF SKILLED NURSING FACILITIES (SNFs)

A. See [Chapter 8, Section 2](#) for the instructions on SNF prospective payment system (PPS).

B. Effective for admissions on or after August 1, 2003, reimbursement will follow Medicare's SNF PPS methodology. With the implementation of SNF PPS, revenue code 022 must be present on all SNF HCSRs in addition to all other revenue code information pertinent to the treatment. See the ADP Manual, [Chapter 2, Addendum F](#) for a list of valid revenue codes. In addition, under SNF PPS all SNF HCSRs must be coded with Special Rate Code "V" Medicare Reimbursement Rate or a discounted rate code "D".

C. With the implementation of SNF PPS, for each calendar quarter, contractors shall deliver a file (on a computer-readable standard IBM cartridge tape or CDROM or diskette) in simple EBCDIC or ASCII data format to Kennell & Associates, 3130 Fairview Park Drive, Suite 505, Falls Church, VA 22042-4550. This file must contain the full HCSR number (21 characters) and the 5-digit Health Insurance Prospective Payment System (HIPPS) code for each SNF claim. This quarterly report file must reflect all SNF claims which have cleared all TMA edits and have been accepted on the HCSR data base in the quarter (whether denied or allowed and regardless of government liability) and shall be delivered within 30 days after the end of each quarter. This SNF report file shall have a record length of 26 and contain the two data elements according to the following file layout:

DATA ELEMENT	Start Byte	End Byte
HCSR-NBR	1	21
HIPPS code	22	26

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